DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 5 — 2 2

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Medicaid

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 1995

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447. 253

7. FEDERAL BUDGET IMPACT:
a. FFY 96 $ 7,800
b. FFY 97 $ 7,800

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A pages 28 thru 30

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A pages 28 thru 30

10. SUBJECT OF AMENDMENT:
Methods and Standards for Establishing Payment Rates - Inpatient Hospitals

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Janet Schalansky is the Governor's designee.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Janet Schalansky

13. TYPED NAME:
Janet Schalansky

14. TITLE:
Deputy Secretary

15. DATE SUBMITTED:
12-26-95

16. RETURN TO:
Janet Schalansky, Deputy Secretary
Social and Rehabilitation Services
915 Harrison, 6th Floor
Topeka, Kansas 66612

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
01/08/96

18. DATE APPROVED:
JUN 06 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/1/95

20. SIGNATURE OF REGIONAL OFFICIAL:
Thomas W. Lenz

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid & State Operations

23. REMARKS:
cc:
Schalansky
Day
Haverkamp

SPA CONTROL

Date Submitted 12/26/95
Date Received 01/08/96

FORM HCFA-179 (07-92)

Instructions on Back

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

6.2000 continued

B6. Hospital revenue from Medicare worksheet G2, column 3, total patient revenue (line 25) - swing bed (lines 4 & 5) - SNF (line 6) - ICF (line 7) - LTCU (line 8) - HHA (line 19) - Ambulance (line 20) - CORF (line 21) - ASC (line 22) - Hospice (line 23).

B7. Cost to revenue ratio (B5 / B6).

B8. Hospital revenue attributable to the inpatient portion of State and local government funds (B4 / B7).

B9. Unduplicated charity care charges (B1 - B8. If this is negative, use 0).

B10. Ratio of unduplicated charity care to total inpatient revenue (B9 / A5).

C1. Low-Income utilization rate (A11 + B10).

Payment Adjustment

If the low-income utilization rate in C1 above exceeds 25%, then the excess over 25% shall be multiplied by 10 and the resulting number shall be multiplied by the amount of Kansas Medicaid/MediKan (excluding prior disproportionate share payments) payments for services received in the State Fiscal Year ending two years prior to the year of the administration of a disproportionate payment adjustment. For example 1995 state fiscal year payment adjustment shall be based upon state fiscal year 1993 Kansas Medicaid/MediKan annual payment.

For the purposes of disproportionate share, outpatient services are those services which are provided on an outpatient basis either by a hospital or under a contractual agreement with a hospital and reported in the hospital's cost report. In the case where one hospital contracts with another hospital to provide outpatient services, only the contracting hospital, and not the hospital actually providing services, may report the outpatient services.

An example of both the eligibility and payment adjustment computations are attached.

6.3000 Simultaneous Option 1 and Option 2 Eligibility

If a hospital is eligible under both 6.1000 and 6.2000, the disproportionate share payment adjustment shall be the greater of these two options.

6.4000 Request for Review

If a hospital is not determined eligible for disproportionate share payment adjustment according to 6.1000 or 6.2000, a hospital may request in writing a review of the determination within 30 days from the notification of the final payment adjustment amount. Any data supporting the redetermination of eligibility must be provided with the written request.

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

6.5000 Payment Limitations

If the payments determined exceed the allotment determined by HCFA in accordance with section 1923(f)(1)(C) of the Social Security Act, then all hospitals eligible for disproportionate share shall have their disproportionate share payments reduced by an equivalent percentage which will result in an aggregate payment equal to the allotment determined by HCFA. In order to be eligible, the hospital must have a minimum medical utilization of 1%, as determined in Option 1.

All hospitals are limited to no more than 100% of the cost of the uninsured plus the difference between the cost of the Kansas Medicaid inpatient services and the payments for Kansas Medicaid inpatient services. Previous years data for both the uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Kansas Medicaid inpatient costs shall be made upon receipt of the appropriate cost report.

State of Kansas
Department of Social and Rehabilitation Services

Disproportionate Share Low-Income Utilization

All data on this schedule, except where specifically noted, should only include hospital inpatient data. Do not include SNF, ICF, long term care units, home health agency, swing bed, ambulance, durable medical equipment, CORF, ambulatory sugical center, hospice or non-reimbursable cost centers. Although specific line numbers from the Medicare Cost Reports are given, if blank lines on the Medicare Cost Report are used by the hospital, the blank lines should also be included or excluded, as appropriate, where there are similar references.

Hospital Name _____

Kansas Medicaid Number _____ **Fiscal Year Ending** _____

A1	Medicaid/Medikan inpatient payments for the most recent available hospital fiscal year, excluding disproportionate share payemnts. Contact SRS Medical Fiscal (913-296-3981) for a log summary.	_____

Other State and local government income. Provide source and description. Disproportionate share payments should not be included here. (Medicare Worksheet G-3, Governmental appropriations (Line 23))

A2	_____	_____
A3	_____	_____
A4	Total Medicaid/Medikan, State and local government funds. (A1 + A2 + A3)	_____
A5	Inpatient Revenues (Medicare Worksheet G-2 Column 1, Total Inpatient Routine Care Services (Line 16) + Ancillary (Line 17) + Outpatient (Line 18) - Swing Bed (Line 4 & 5) - SNF (Line 6) - ICF (Line 7) - LTCU (Line 8))	_____
A6	Total patient revenues (Medicare Worksheet G-2, Line 25, Column 3)	_____
A7	Ratio of inpatient revenues to total patient revenues (A5 ÷ A6)	_____
A8	Contractual Allowances and discounts (Medicare Worksheet G-3, Line 2)	_____
A9	Inpatient share of contractual allowances and discounts (A7 × A8)	_____
A10	Net inpatient revenue (A5 - A9)	_____
A11	Ratio of Medicaid/Medikan, State and local government funds to net inpatient revenue (A4 ÷ A10)	_____
B1	Inpatient charity care charges. Charity care is considered to be any unpaid charge made directly to a patient where a reasonable effort has been made to collect the charge. This would include spendown incurred by a Medicaid recipient, the deductible on insured patients, and the entire charge of private pay patients, providing a reasonable attempt to collect the amount due has been made. This should also include the portion of any sliding fee scale which is not billed to the patient. It would not include any amount billed but not paid by a third party, such as Medicaid, Medikan, Medicare, or insurance (contractual allowance) or third party or employee discounts. Information to support this number must be maintained by the hospital and is subject to review.	_____
B2	Other State and local government funds (A2 + A3)	_____
B3	Ratio of inpatient revenues to total patient revenues (A7)	_____
B4	Inpatient portion of State and local government funds (B2 × B3)	_____
B5	Hospital costs (Medicare Worksheet B Part I, Total Column, Subtotal (Line 95)) - SNF (Line 34) - ICF (Line 35) - LTCU (Line 36) - Ambulance	

(Line 65) - DME (Line 66 & 67) - Medicare (Line 69) - Unapproved Teaching (Line 70) - HHA (Line 71 through 81) - CORF (Line 82) - HHA (Line 89 & 90) - ASC (Line 92) - Hospice (Line 93))

B6 Hospital revenue (Medicare Worksheet G2, Column3, Total Patient Revenue (Line 25) - Swing Bed (Line 4 & 5) - SNF (Line 6) - ICF (Line 7) - LTCU (Line 8) - HHA (Line 19) - Ambulance (Line 20) - CORF (Line 21) - ASC (Line 22) - Hospice (Line 23)

B7 Cost to revenue ratio (B5 ÷ B6)

B8 Hospital revenue attributable to the inpatient portion of State and local government funds (B4 ÷ B7)

B9 Unduplicated charity care charges (B1 - B8 (if negative use 0))

B10 Ratio of unduplicated charity care to total inpatient revenue (B9 ÷ A5)

C1 Low-Income utilization rate (A11 + B10)

The section below only applies if C1 exceeds 0.25. If C1 exceeds 0.25 (25%), then the hospital is eligible for a disproportionate share payment as computed below (subject to verification).

C2 Excess over 25% (C1 - 0.25)

C3 Ten times the excess over 25% (C2 × 10)

C4 Kansas Medicaid/Medikan inpatient payments for services rendered in the State fiscal year ending two years prior to the year of the disproportionate share payment, excluding previous disproportionate share payments. (See attached schedule)

E1 Hospital Limitation. All hospitals are limited to no more than 100% of their net Medicaid cost plus uninsured for FY 1995. The uninsured are only those patients shown in charity care (B1) for which no other payment is received. In addition outpatient charity care which is provided in the state of Kansas which is not included in line B1 may be reported here. **Report the uninsured here.** Do not report Medicaid here. SRS shall compute the Medicaid limitation. This line must be completed by all hospitals or no disproportionate share payments will be made.

D2 Estimated disproportionate share computation
(Lesser of D1 or C3 × C4 for public hospitals, C3 x C4 for others)

I declare that I have examined this statement, and to the best of my knowledge and belief, it is true, correct, complete, and in agreement with the books maintained by the facility. **I understand that the misrepresentation or falsification of any information set forth in this statement may be prosecuted under applicable Federal and/or State law.**

Signature of Officer/Administrator

Title

Date